Brent D. Sherard, M.D., M.P.H., Director and State Health Officer **Governor Dave Freudenthal**

Rights And Responsibilities

By signing this notification, you state that you understand the following:

Release of Medical Records

I understand that the Wyoming Department of Health (WDH) must be able to obtain medical records from providers if necessary. My signature authorizes my medical provider to release any medical records to the WDH.

Social Security Numbers:

I understand that I have to provide my SSN on this application because I am applying for benefits. My SSN will be used to verify any current Medicaid benefits being received, to check for duplication, and to verify information I have provided.

My Civil Rights

I understand that the program this application is used for will not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, religion, political belief, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of this program. For further information about this policy contact: Wyoming Department of Health at (307)777-7531 or the Office of Civil Rights at (800) 368-1019.

Medical Support

I understand that if WDH pays for medical or other related services, they have the right to collect from a third person or from available insurance or from settlements for accidents or injuries. If I receive any medical reimbursement payments from insurance companies or other potentially liable third parties while I am enrolled in EqualityCare, I must pay WDH back.

Verification of Application Information

I understand that my case may be reviewed to see what kind of service I received and to make sure that my benefits were determined correctly. My signature (or the signature of my representative) authorizes State and Federal officials to get and use computerized and other information about me to determine if I am eligible for benefits. Computer cross checking may be used to verify information I have provided on this application. I must cooperate fully with state and local workers if my application is selected for review.

Required Signature

I do allow any person having this information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal government. This information will be used for the purpose of determining eligibility for the programs for which I am applying. I also agree to provide information necessary to verify any statement given on this application, to update information promptly and to cooperate fully with all officials of the State of Wyoming in investigations and prosecution of actions based upon this application or the information it contains. A copy of this authorization is as valid as the original.

I certify that the information given on this form is true and correct. I also have read and understand the Rights and Responsibilities on this notification.

Please sign here _____ **Date** _____

Application Information Provided :

<<ApplicationFields>>